name and address, should be attached to the completed Medical Plan Prescription Drug Claim Form.

Providing Blue Cross and Blue Shield with correct, complete and accurate information as requested on the Claim Forms helps assure that your claims will be processed in a routine manner. For your reference, you may make and keep copies of your Claim Forms, bills and any other supporting records before submitting your claims.

SECOND/THIRD SURGICAL OPINION CLAIMS QCP-Listed Physician

When the physician providing you with the second or third surgical opinion is a QCP-listed physician, you should not pay the physician.

QCP-Approved Physician

When the physician is a QCP-approved but not QCP-listed physician, ask the physician to forward the completed Second Surgical Opinion Report Form directly to:

United HealthCare, Inc.
BellSouth Quality Care Program
1575 Northside Drive
200 Atlanta Technology Center — Suite 100
Atlanta, Georgia 30318

Bills for second or third surgical opinions must be forwarded directly to United HealthCare at the above address. Payment will be made directly to the physician.

HOW BENEFITS ARE PAID

The following examples illustrate how MAP benefits are paid. In the first two examples, QCP must pre-certify the hospital admission in order to avoid the QCP Penalty. In the third example, QCP must pre-certify the

surgery since the surgical procedure is on the Mandatory Second Surgical Opinion List. However, for purposes of these examples, we have <u>not</u> assumed QCP or PPO compliance to illustrate the cost implications of non-compliance.

In addition, dollar amounts have been rounded to the nearest dollar.

Example 1

F

An employee, as his first expense for the year, goes to the doctor's office in March of 1990, and is diagnosed as having the flu. The doctor prescribes medication and asks the employee to call if he doesn't feel better at the end of the week. He was charged \$35 for the office visit and the cost of the generic medication he purchased from a local pharmacy was \$20.

At the end of the week, the employee calls the doctor and says he still feels ill. The doctor examines the employee in his office again and then refers him to the hospital with a diagnosis of pneumonia.

The doctor's charge for the second office visit is another \$35. The doctor's charges for hospital visits total \$390. All of the doctor's charges are within R&C limits. The PPO hospital bill for a semi-private room, board and ancillary charges would be \$2,460; the same admission to a non-PPO hospital in the same PPO area would cost \$3,624. The PA limit for the non-PPO hospital charge is \$2,692.

With PPO Compliance/With QCP Certification

Assume the physician charges were within R&C limits; all charges are covered by MAP; and the charges are the first claim submitted by the employee for the calendar year.

			,	MAP PAYS				
	Ch	arges	PPO Hospital Care (100%)	Medical Care (90% R&C)	MAP Pays	•	lo yes sys	Expenses Applied To Out-Of-Pocket Limit
PHYSICIAN (office visits)	\$	70	•	0 (\$70 applied toward deductible)	0	\$	70	0
PRESCRIPTION DRUGS	\$	20	•	0 (\$20 applied toward deductible)	0	\$	20	0
PHYSICIAN (hospital visits)	\$	390	-	\$284 (\$75 applied toward deductible; then 90% of remaining \$315 = \$284)	\$ 284	\$ 1	106	\$31
PPO HOSPITAL (semi-private room, board, ancillary charges)	\$2	2,460	\$2,460	•	\$2,460		0	0
TOTALS	\$2	2,940	\$2,460	\$284 (\$165 deductible	\$2,744	\$	196	\$31

With PPO Compliance/Without QCP Certification

MAP Pays	Employee Pays	Expenses Applied To Out-Of-Pocket Limit
\$2,494	\$446	\$31

Without PPO Compliance

If the employee lives in a PPO area but does not use a PPO hospital, MAP will pay 90% of PA (\$2,692) for the hospital charge. The non-PPO hospital charged \$3,624. MAP will pay \$2,423 (90% x \$2,692) of the hospital charges.

			Expenses Applied To
	MAP Pays	Employee Pays	Out-Of-Pocket Limit
With QCP Certification	\$2,707	\$1,397	\$300
Without QCP Certification	2,457	1,647	300

If a non-PPO hospital charge was incurred and the employee does not live in a PPO area, MAP would have paid 100% of covered charges billed from that non-PPO hospital.

Example 2

An employee has a March, 1990, maternity care bill for \$1,400 from her obstetrician; the anesthesiologist charges her \$300 for administering the anesthesia; and the pediatrician charges \$50 for the routine well baby examination. She also has a \$150 bill for home health care. All these charges are within R&C limits. Also, her deductible has been met.

The PPO hospital charge for her 3 days of maternity care would total \$2,457; the non-PPO hospital charge for her maternity care would total \$3,592. The PA limit is \$2,340.

With PPO Compliance/With QCP Certification

Assume the charges are within R&C limits and covered by MAP; submitted after the employee has satisfied the annual deductible requirement; and before any expenses have been applied toward her out-of-pocket limit.

			MA	P P	AYS			
	Charges	PPO Hosp. Care (100%)	Surgical Care (100% R&C)	Medical Care (90% R&C)	Alternate Benefits (100% R&C)	MAP Pays	Employee Pays	Expenses Applied To Out-Of-Pocket Limit
OBSTETRICIAN (pre/postnatal care)	\$1,400	•	\$1,400	-	-	\$1,400	0	0
PPO HOSPITAL (semi-private room, board, ancillary charges)	\$2,457	\$2,457		•	-	\$2,457	0	0
ANESTHESIA	\$ 300	-	-	\$270	•	\$ 270	\$30	\$30
WELL BABY CARE VISIT HOME	\$ 50		-	\$ 45		\$ 45	\$ 5	\$ 5
HEALTH CARE	\$ 150	·			\$150	\$ 150	0	0
TOTALS	\$4,357	\$2,457	\$1,400	\$315	\$150	\$4,322	\$35	\$35

With PPO Compliance/Without QCP Certification*

		Expenses Applied To
MAP Pays	Employee Pays	Out-Of-Pocket Limit
\$3,922	\$435	\$35

* QCP certification is required if a maternity stay is expected to last longer than 48 hours; QCP pre-certification is required for home health care to be a covered expense.

Without PPO Compliance

If the employee lives in a PPO area but does not use a PPO hospital, MAP will pay 90% of PA (\$2,340) for the hospital charge. The non-PPO hospital charged \$3,592. Therefore, MAP will pay \$2,106 (90% X \$2,340) of the hospital charge.

	MAP Pays	Employee Pays	Expenses Applied To Out-Of-Pocket Limit
With QCP Certification	\$3,971	\$1,521	\$269
Without QCP Certification*	3,571	1,921	269

If a non-PPO hospital charge was incurred but the employee does not live in a PPO area, MAP would have paid 100% of covered charges billed from that non-PPO hospital.

* QCP certification is required if a maternity stay is expected to last longer than 48 hours; QCP pre-certification is required for home health care to be a covered expense.

Example 3

An employee had Dilation and Curettage (D&C) surgery performed in March, 1991, on an outpatient basis.

Assume the charges were:

- . Covered by MAP up to MAP limits, and
- Before any expenses have been applied toward her deductible or out-of-pocket limit.

With PPO Compliance/With QCP Certification

Since the surgery is on both the Mandatory Outpatient Surgical Procedures List and the Second Surgical Opinion List, here's what MAP will pay:

		M	AP PAY	S		
	Charges	Hospital Care (100%)	Outpatient Surgical Care (90% Less \$5 Copayment)	MAP Pays	Employee Pays	Expenses Applied To Out-Of-Pocket Limit
PPO SURGEON	\$ 580	•	\$517	\$ 517	\$ 63	\$58
PPO HOSPITAL (outpatient)	\$ 980	\$980		\$ 980	0	0
TOTALS	\$1,560	\$980	\$517	\$1,497	\$ 63	\$58

With PPO Compliance/Without QCP Certification

MAP Pays	Employee Pays	Expenses Applied To Out-Of-Pocket Limit
\$1,247	\$313	\$58

Without PPO Compliance

If the employee lives in a PPO area but does not use a PPO hospital or PPO physician, MAP will pay 90% of PA (\$850) for the hospital charge and 80% of PA (\$520) for the physician's charge.

The non-PPO hospital charged \$1,250; therefore, MAP will pay \$765 (90% x \$850) of the hospital charge.

The non-PPO physician charged \$600; therefore, MAP will pay \$284 [80% x (\$520 - \$165 deductible)] of the surgeon's bill.

	MAP Pays	Employee Pays	Expenses Applied To Out-Of-Pocket Limit
With QCP Certification Without QCP Certification	\$1,049	\$ 801	\$156
	799	1,051	156

SECTION 15. WHEN COVERAGE ENDS OR CHANGES

There are several circumstances in which the coverage you have as an active employee or retiree can end or change that you need to know about.

TERMINATION OF COVERAGE

Coverage ends if your employment terminates for reasons other than retirement on a service or disability pension, receipt of LTD benefits, layoff, termination under the provisions of one of the force-adjustment plans, or death. Coverage ends on the last day of the month in which your employment ends.

Coverage also ends on the last day of the month in which:

- You request, for any reason, that your coverage be cancelled;
- · A required payment is not made; or
- You begin a military leave.

If your coverage ends, your dependents' coverage ends too. A dependent's coverage will also end on the last day of the month in which:

- · A required payment is not made, or
- A dependent no longer qualifies as a dependent (Section 1) because of age, a change in full-time student status, marital status, residency or income.

If coverage ends at the end of a month, no benefits for expenses incurred after the end of that month will be paid by MAP — unless the participant is in the hospital on the last day of that month. If so, only Hospital Care Benefits, as described in Section 7, will continue to be paid for the remaining days of that admission; then all benefits end.

Continued Coverage Under COBRA

If you terminate employment for reasons other than gross misconduct, you or your covered dependents may elect to continue coverage under COBRA, as explained in Section 16, by paying 102% of the group rate for up to 18 months. At the appropriate time, the Company will provide you with information on how to elect continued coverage under COBRA.

If your dependent no longer qualifies as a dependent under MAP, COBRA Coverage is also available.

WHEN YOU RETIRE

If you retire from the Company on a service or disability pension, the Company currently continues your coverage and coverage for your eligible dependents during your retirement through the last day of the month in which you die. However, the Company reserves the right to change or modify coverage, including reduction, elimination of coverage, or requiring retirees to pay all or a greater portion of the cost of coverage, at its discretion. Also, if you retire on or after January 1, 1988 and then go to work for a BellSouth competitor within your first five years of retiring from BellSouth, your coverage and your dependents' coverage will end on the last day of the month your new employment begins and it will not be reinstated.

If you are a covered retiree under MAP when you die, your surviving spouse may continue coverage as explained on pages 91-93.

Retiree coverage currently is the same as coverage for active employees with the following exceptions which begin on the January 1 following your retirement:

 The individual lifetime benefit maximum of \$1,000,000 applies to all MAP payments for each retiree and dependent, and Benefits will be reduced by payments available from Medicare.

The cost of retiree coverage is explained in Section 4.

Continued Coverage Under COBRA

As an alternative to the coverage described on the prior page, you or your covered dependents may be eligible to elect to continue coverage under COBRA, as explained in Section 16, by paying 102% of the group rate for up to 18 months. At the appropriate time, the Company will provide you with information on how to elect continued coverage under COBRA.

If COBRA Coverage is elected, MAP currently provides that the then applicable, if any, retiree coverage (as explained in the previous paragraphs) will automatically begin when COBRA Coverage ends for any reason.

IF YOU BECOME DISABLED

If you become disabled before retirement and are eligible to receive benefits under one of the Company's Long Term Disability (LTD) Plans, MAP coverage for you and your dependents will continue.

Coverage is currently the same as for active employees with the following exceptions:

- The individual lifetime benefit maximum of \$1,000,000 applies to you and each dependent beginning on the January 1 following your eligibility for LTD benefits, and
- There are no substance abuse rehabilitation benefits for expenses incurred by you or your dependents on or after the first day of the month following your eligibility for LTD benefits.

The Company currently pays the full cost of coverage for you and your Class I dependents while you are an LTD eligible — with regular contributions required for all other dependents. However, the Company reserves the right to change or modify coverage, including reduction, elimination of coverage, or requiring you to pay all or a portion of the cost of coverage, at its discretion, subject to applicable collective bargaining agreements.

Continued Coverage Under COBRA

As an alternative to the coverage described on the prior page, you or your covered dependents may be eligible to elect to continue coverage under COBRA, as explained in Section 16, by paying 102% of the group rate for up to 18 months. If you are receiving Social Security disability benefits, the 18-month period may be extended to a 29-month period by paying 150% of the group rate during the 19 through 29 months. At the appropriate time, the Company will provide you with information on how to elect continued coverage under COBRA.

If COBRA Coverage is elected, MAP currently provides that the then applicable coverage for LTD eligibles, if any, (as explained in the previous paragraphs) will automatically begin when COBRA Coverage ends for any reason.

WHEN YOU DIE

If you die while you are an employee or retired employee, MAP currently provides that coverage may continue for your surviving spouse and your Class I dependents who are covered on the date of your death. Dependent coverage will continue unless you do not have a surviving spouse, in which case benefits for your Class I dependents will end on the last day of the month in which you die. In addition, coverage for your Class II dependents and sponsored children will end on the last day of the month in which you die.

Your surviving spouse may elect to continue coverage on himself or herself and your Class I dependents. The Company currently pays for continued coverage for the first six months at the current contribution rate. Following the last day of the sixth month after your death, your spouse may elect coverage by paying 100% of the group rate.

Coverage for a surviving spouse and Class I dependents of an **active** employee is currently the same as for active employees except:

- The coverage is only available for Class I dependents who are covered on the day of your death — your spouse cannot enroll any new Class I dependents, Class II dependents or sponsored children, and
- There is an individual lifetime benefit maximum of \$1,000,000 which applies to all MAP payments beginning on the January 1 following each participant's (your spouse's and each dependent's) 65th birthday.

Coverage for a surviving spouse and Class I dependents of a **retired** employee is currently the same as for retired employees except:

 The coverage is only available for Class I dependents who are covered on the day of your death — your spouse cannot enroll any new Class I dependents, Class II dependents or sponsored children.

The Company reserves the right to change or modify coverage, including reduction, elimination of coverage, or requiring a surviving spouse to pay all or a greater portion of the cost of coverage, at its discretion.

Continued Coverage Under COBRA

As an alternative to the coverage described above, your covered dependents may elect to continue coverage under

COBRA, as explained in Section 16, by paying 102% of the group rate for up to 36 months. At the appropriate time, the Company will provide your dependents with information on how to elect continued coverage under COBRA.

If COBRA Coverage is elected, your surviving spouse and Class I dependents will automatically be eligible for the coverage MAP currently provides for the then applicable survivor coverage, if any, according to Company policy (explained in the previous paragraphs) when COBRA Coverage ends for any reason.

LEAVE OF ABSENCE

In the case of an <u>approved</u> Leave of Absence, MAP currently provides that you can continue coverage for yourself and your dependents for the duration of the approved leave request by paying the full cost — unless the leave is an <u>approved</u> Care of a Newborn Child (CNC) Leave or Dependent Care Leave. In that case, on or after January 1, 1990, the Company will pay the full cost of MAP coverage for up to 6 months during the leave in any 2-year period — if you were eligible to receive Company-paid coverage prior to the CNC or Dependent Care Leave.

Under MAP, a leave to enter military service is not considered an "approved leave". If you enter military service, your coverage and your dependents' coverage will end on the last day of the month in which you are an active employee.

If you are planning to go on an approved Leave of Absence (other than military leave) and you are also an eligible dependent of an active employee, you may request to transfer your medical coverage as an active employee to coverage as a dependent of an active employee without any break in coverage. Your request should be made <u>before</u> your Leave of Absence begins.

The Company reserves the right to change or modify coverage, including reduction or elimination of coverage, at its discretion, subject to applicable collective bargaining agreements.

Continued Coverage Under COBRA

If you are on an approved Leave of Absence, are covered by MAP, and do not return to work at the termination of that leave, you or your dependents may elect to continue coverage under COBRA for up to 18 months, as explained in Section 16, by paying 102% of the group rate.

EXTENDED MEDICAL COVERAGE

Former employees covered under MAP who are not eligible for a Company service or disability pension and are either laid off or leave the Company under the provisions of one of the force-adjustment plans, currently may continue coverage for up to 12 months (based on the terms of their force-adjustment plan) beginning on the first day of the month following layoff. The period of Company contributions for continued coverage is currently based on net credited service as follows:

- Former employees with five or more years of net credited service will continue to receive current levels of Companypaid medical coverage for up to six months. The former employee may then continue coverage for the next six months by paying 100% of the monthly group rate.
- Former employees with more than one year but less than five years of net credited service will receive three months of the current level of Company-paid coverage with an option to pay 100% of the group rate for coverage for an additional nine months.
- An employee with less than one year of service may elect to pay 100% of the group rate for coverage for twelve months.

The continued coverage will be the same as the coverage then provided to active employees. Therefore, any changes in benefits or contributions for active employees will be applied to participants in this extended medical coverage program. However, the Company reserves the right to change or modify coverage, including reduction, elimination of coverage, or requiring former employees to pay all or a greater portion of the cost of coverage, at its discretion, subject to applicable collective bargaining agreements.

Continued Coverage Under COBRA

Once the former employee's right to extended coverage ends, the former employee or his or her covered dependents may be eligible to elect to continue coverage under COBRA (Section 16) for up to an <u>additional</u> six months by paying 102% of the group rate. At the appropriate time, the Company will provide you with information on how to elect continued coverage under COBRA.

CONVERSION RIGHTS

If coverage terminates either for you or one of your dependents and COBRA Coverage (Section 16) is not elected, you currently may be able to convert coverage to a non-group policy issued by Blue Cross and Blue Shield.

This non-group coverage currently provides hospital, surgical and medical benefits similar (but not necessarily the same) to those provided by MAP. No medical examination will be required. You must file a written request for this coverage directly with Blue Cross and Blue Shield within 31 days after your coverage ends unless you purchase COBRA Coverage.

If you elect COBRA Coverage and conversion rights are otherwise generally available under MAP when your COBRA Coverage terminates, you will have 31 days from the date your COBRA Coverage ends to convert to a non-group policy.

SECTION 16. YOUR COBRA RIGHTS

In 1986, a federal law — the Consolidated Omnibus Budget Reconciliation Act (COBRA) — was enacted requiring that most employers sponsoring group health plans offer employees and their dependents the opportunity for a temporary extension of health coverage (called "COBRA Coverage") at 102% of group rates in certain instances where coverage would otherwise end or change.

The information in this Section is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. You, your spouse and your other covered dependents should read this Section carefully.

If you are an active, regular employee (or a regular employee on approved Leave of Absence) covered by the BellSouth Medical Assistance Plan or an alternative Health Maintenance Organization (referred to in this Section as the "Plan"), you have a right to choose COBRA Coverage for yourself and your covered dependents if you lose your coverage or if your coverage changes because of the termination of your employment (for reasons other than gross misconduct on your part) or a reduction in hours.

If you are the spouse of an employee covered by the Plan, you have the right to choose COBRA Coverage for yourself and your covered dependents if your coverage ends or changes for any of the following three events:

- 1. The death of your spouse;
- 2. A termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment; or
- 3. Divorce from your spouse.

In the case of a covered dependent, he or she has the right to elect COBRA Coverage for himself or herself if coverage ends or changes for any of the following four events:

- 1. The death of a covered employee or former employee;
- 2. The termination of the covered employee's employment (for reasons other than gross misconduct) or a reduction in the covered employee's hours;
- 3. Divorce; or
- 4. The dependent ceases to be a dependent under the provisions of the Plan, for example, because of age or financial dependency.

Under the law, the employee or a family member has the responsibility to inform the Benefit Office within 60 days after losing coverage because of a divorce or dependent losing dependent status as defined in Section 1. The Company has the responsibility to notify the appropriate Benefit Office of the employee's death or termination of employment.

When the Benefit Office is notified that one of these events has happened, they will notify you that you have the right to choose COBRA Coverage. Under the law, you have 60 days from the <u>later</u> of the following two dates to inform the Benefit Office you want COBRA Coverage:

- The date you would lose coverage or coverage would change because of one of the events described above, or
- 2. The date the COBRA Election Form is sent to you from the Benefit Office.

If you do not choose COBRA Coverage, your coverage will end or change in accordance with MAP's provisions.

If you choose COBRA Coverage, the Company is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated active employees. The law requires that you be afforded the opportunity to maintain COBRA Coverage for 3 years unless you lost coverage or coverage changed because of a termination of employment or reduction in hours. In those cases, the required COBRA Coverage period is 18 months. However, the 18-month period may be extended to a 29-month period if you are receiving Social Security disability benefits.

The law also provides that your COBRA Coverage may be cut short for any of the following four reasons:

- 1. The Company no longer provides any group health coverage to any of its employees;
- 2. The charge for your COBRA Coverage is not paid on a timely basis;
- You become covered as an employee or otherwise under another group medical plan — unless the new coverage contains an exclusion or limitation which affects the COBRA-covered individual due to a preexisting condition; or
- 4. You become entitled to Medicare.

You do not have to show that you are insurable to elect COBRA Coverage. However, under the law, you will have to pay up to 102% of the group rate for your COBRA Coverage during your 18-month or 3-year continuation coverage period. In addition, if you are receiving Social Security disability benefits, the cost of your COBRA Coverage during your 19 through 29 months of extended coverage will be 150% of the group rate.

The law also says that at the end of the maximum available continuation coverage period (18, 29 or 36 months), you

must be allowed to convert your coverage to an individual health plan then provided under MAP to the extent that, and under the same terms and conditions, an individual conversion right otherwise is generally available to similarly situated active employees when your COBRA Coverage terminates.

SECTION 17. OTHER IMPORTANT INFORMATION

Introduction

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA) to safeguard your interests and those of your beneficiaries under your employee benefit plans. As ERISA requires, this Section provides additional information about your benefits as well as a statement of your rights and protections under this law.

Funding

BellSouth currently provides for the payment of MAP benefits through one of the two established Trusts. One Trust is for management employees and the other is a negotiated Trust that covers non-management employees. These Trusts fund post-retirement and active health benefits for employees and their covered dependents. The Trusts also accept participant contributions for medical coverage. In addition, the Participating Companies make periodic contributions to the Trusts to meet MAP's obligations. The Trustee is:

Citizens and Southern National Bank Suite 100 33 North Avenue ` Atlanta, Georgia 30308

Name And Type Of Plan

The name of this Plan is the Medical Assistance Plan. The Plan is classified under ERISA as a "welfare plan" because it provides medical, surgical and hospital benefits.

Plan Administrator

The Plan Administrator is BellSouth Corporation; Room 7B09; 1155 Peachtree Street, N.E.; Atlanta, Georgia 30367-6000; telephone number 404-249-2355.

BellSouth has delegated responsibility for handling Plan administrative services for each Participating Company as follows:

- · BellSouth Enterprises, Inc.
- BellSouth Communications, Inc.
- BellSouth Financial Services Corporation
- · BellSouth Information Systems, Inc.
- · BellSouth International, Inc.
- BellSouth Resources, Inc.
- Sunlink Corporation Secretary BellSouth Enterprises Employees' Benefit Committee Suite 803
- 1201 Peachtree Street Atlanta, Georgia 30309 Telephone: 404-249-4175
- BellSouth Advertising & Publishing Corporation Assistant Secretary BellSouth Enterprises Employees' Benefit Committee 59 Executive Park South, N.E. Atlanta, Georgia 30329 Telephone: 404-982-7027
- BellSouth Mobility Inc Assistant Secretary
 BellSouth Enterprises Employees' Benefit Committee Suite 600
 5600 Glenridge Drive Atlanta, Georgia 30342
 Telephone: 404-847-3650

- BellSouth Human Resources Administration, Inc.
- BellSouth Corporation
- BellSouth D.C., Inc.
- BellSouth Services Incorporated
- South Central Bell Telephone Company
- Southern Bell Telephone and Telegraph Company

ACTIVES:

Secretary

Employees' Benefit Committee

Suite 1400

3000 Riverchase Galleria

Birmingham, Alabama 35244

Telephone: 1-557-6179 (AL, KY, LA, MS, TN)

780-2029 (FL, GA, NC, SC)

205-733-3001, collect (all other states)

RETIREES:

Operations Manager

BellSouth Human Resources Administration

Room 18H62

Southern Bell Center

675 W. Peachtree Street

Atlanta, Georgia 30375

Telephone: 1-800-633-8915

Plan Administration

BellSouth has delegated to Blue Cross and Blue Shield (and United HealthCare, Inc. with respect to QCP) the duty to administer all claims for Plan benefits for all Participating Companies. The Administrative Service Agreement between BellSouth Corporation and Blue Cross and Blue Shield governs the operation of the Plan at all times. This agreement designates Blue Cross and Blue Shield as the Claims Administrator. Blue Cross and Blue Shield and, with respect to QCP, United HealthCare, Inc., have the right and authority to determine benefits under the Plan and to

interpret the provisions of the Plan, and their determinations and interpretations are final and conclusive.

Subrogation

Subrogation is the substituting of one party for another who has a legal claim against a third party.

Under this Plan, the Company has subrogation rights to receive the cost of medical treatment for you or your covered dependents if the illness or injury was caused by a third party.

You are required to provide the Company with any information it may need to carry out its subrogation rights, and your receipt of any benefits under this Plan is subject to the Company's subrogation rights. Failure to cooperate in supplying the Claims Administrator with necessary information could result in denial of Plan benefits.

- Denial Of Benefits Requests And Appeal Procedures
 If a request for Plan benefits is denied, either in whole or in
 part, you or your dependents will receive written notification
 from Blue Cross and Blue Shield. This written notification
 will include:
 - 1. The specific reason or reasons for the denial;
 - 2. Specific reference to pertinent Plan provisions on which the denial is based;
 - A description of any additional material or information necessary for the individual to perfect the benefit request and an explanation of why such material or information is necessary; and
 - 4. Appropriate information as to the steps to be taken if you, your dependent, or a duly authorized person representing you or your dependent, wish to submit the benefit request for review.

However, if you do not hear from Blue Cross and Blue Shield within 90 days after your benefit request has been submitted according to the procedures in Section 14 of this booklet, your request is considered denied.

If a request for benefits is denied or you or your dependent feel you have been treated unfairly with respect to the Plan, you, your dependent or other duly authorized person may appeal this denial or other action in writing within 60 days after your receipt of notification of the decision or, if no such notification is received, within 60 days after the 90-day period discussed above has lapsed. Written request for review of any denied benefit payment or other disputed matter should be sent directly to Blue Cross and Blue Shield. Any request should be accompanied by documents or records in support of the appeal. The person sending the request has the right to:

- 1. Review pertinent Plan documents which may be obtained by following the procedures described in this booklet under "Plan Documents" on page 106, and
- 2. Send Blue Cross and Blue Shield a written statement of the issues and any other documents in support of the request for benefits or other matter under review.

Blue Cross and Blue Shield is responsible for coordinating the appeals process under ERISA for all denials reported on the "Claims Report" except those involving enrollment status. The "Claims Report" will direct the claimant to the appropriate Benefit Committee Secretary, Assistant Secretary or Operations Manager as shown on pages 101-102, in any case involving a denial based on ineligibility of the claimant.

If any part of any denial is based on a decision by United HealthCare, they will re-evaluate their decision and provide a final determination to Blue Cross and Blue Shield for use in notification of the claimant. Likewise, Blue Cross and Blue Shield will re-evaluate any part of the denial that is based solely on its decision and make a final determination.

In all appeal cases, a response will be provided to the claimant within 60 days after the appeal is received.

As a participant in the Plan, you may have further rights under ERISA (page 107). In this respect, BellSouth, the Plan Administrator, retains the right to interpret the Plan's provisions and to make final decisions regarding covered expenses and eligibility.

Legal Service

Service of legal process in a cause of action with respect to any and all provisions of the Administrative Service Agreement should be directed to Blue Cross and Blue Shield; Appeals Coordinator; Post Office Box 13126; Birmingham, Alabama 35202-3126.

Service of legal process concerning the Plan may also be directed to the appropriate Benefit Committee Secretary, Assistant Secretary or Operations Manager listed under "Plan Administrator" on pages 101-102 of this booklet or to the Trustee at the address listed on page 100.

Plan Records

The Medical Assistance Plan and all of its records are kept on a calendar-year basis.

Plan Identification Numbers

The Plan is identified by the following numbers under Internal Revenue Service (IRS) rules:

Employer Identification Number assigned to BellSouth Corporation by the IRS: 58-1533433

Plan Number assigned by the Company: 540

Plan Continuance

The Company currently intends to continue the Medical Assistance Plan for active employees, former employees and retirees, under the terms of the Plan, but reserves the right to amend or terminate it at any time, subject to any applicable collective bargaining agreements.

The benefits described in this booklet reflect the provisions of the Medical Assistance Plan as outlined in the current agreements, if any, between the Participating Companies and the various unions representing employees of those Companies in collective bargaining units. Copies of these agreements are distributed or made available to employees covered by them upon request.

Plan Documents

This booklet is a summary of the Medical Assistance Plan and does not attempt to cover all details. Specific details are contained in the Administrative Service Agreement between Blue Cross and Blue Shield and BellSouth Corporation which legally governs the operation of the Plan.

Plan participants are entitled to examine, without charge, Plan contracts and documents, including the Administrative Service Agreement, the annual report of Plan operations, and such other documents and reports that are maintained by the Plan or filed with a federal government agency. These contracts and documents are available for review during normal working hours at a participant's local Benefit Office. If participants are unable to examine these contracts and documents there, they should write to the appropriate Benefit Committee Secretary, Assistant Secretary or Operations Manager listed under "Plan Administrator" on pages 101-102 of this booklet, specifying the contracts and documents to be examined and at which Company work location they wish to examine them. Copies of such contracts and documents will be made available for examination at that work location within 10 days of the date the request was received.

At any time, participants may request copies of any Plan contracts and documents by writing to the appropriate Benefit Committee Secretary, Assistant Secretary or Operations Manager listed under "Plan Administrator" on pages 101-102 of this booklet. They will be charged a reasonable fee for copies of the contracts and documents requested.

Your Rights As A Plan Participant

The benefits provided by the Medical Assistance Plan are covered by the Employee Retirement Income Security Act of 1974 (ERISA). ERISA was signed into law for the purpose of protecting your rights under employee benefit plans. The law does not require a company to provide benefits, but ERISA does set standards for any benefits a company wishes to offer — and it requires that you be given an opportunity to learn what these benefits are and your rights to them under the law.

It is your right to know as much as possible about your benefits. This Summary Plan Description is one way to help keep you informed. As a participant in the Medical Assistance Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as selected worksites and union halls, all Plan documents, including contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- 2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. A reasonable charge may be made for such copies.
- 3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, call "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants according to the Plan's provisions. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your request for a benefit under this Plan is denied, in whole or in part, you must receive a written explanation of the reasons for the denial. You have the right to formally appeal a denial for review and reconsideration as set forth in "Denial Of Benefits Requests And Appeal Procedures" on page 103.

Under ERISA, there are steps you can take to enforce the rights outlined on the prior pages. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a request for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who will pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your request is frivolous.

If you have any questions about this statement of your rights, or your rights under ERISA, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor.

SECTION 18. MAP BENEFITS AT A GLANCE

This is a summary only of MAP benefits effective on January 1, 1990, and thereafter. Please refer to the specific Sections of this booklet for more details on MAP's limitations, exclusions and provisions.

Item No. Benefit/Plan Feature

- 1. Deductible
- 2. Out-Of-Pocket Limit
- 3. Alternate Benefits
- 4. QCP Penalty
- 5. Outpatient Pre-Admission Testing (Facility Fee)
- 6. In/Outpatient Diagnostic X-Ray And Lab Tests (Facility Fee)
- 7. Inpatient Hospitalization For Medical/Surgical Admission (Facility Fee)
- 8. Ambulatory Surgical Facility/Hospital Outpatient Department (Facility Fee)
- 9. Inpatient Surgery (Surgeon Fee)
- 10. Mandatory Outpatient Surgical Procedures (Surgeon Fee)
- 11. All Other Outpatient Surgery (Surgeon Fee)
- 12. Mandatory Second Surgical Opinions (Physician Fee)
- 13. Anesthesia Administration (Physician Fee)
- 14. Accidental Bodily Injury And Sudden/Serious Illness (Outpatient Charges)
- 15. Pap Smears (Lab Fee)
- 16. Mammogram Screening (Test Fee)
- 17. In/Outpatient Radiation Therapy And Chemotherapy
- 18. In-Hospital Primary Physician's Visit
- 19. In-Hospital Consultation By Other Than Primary Physician
- 20. Physician Fee (Office Visit)
- 21. Physician Fee (Effective 1/1/91)
- 22. Maternity Care (OB Fee For Pre And Postnatal Care)
- 23. Well Baby Care
- 24. Well Child Care
- 25. Chiropractic Charges
- 26. Adoption Coverage
- 27. Mental And Nervous Care
- 28. Inpatient Detox For Alcohol And Drug Abuse
- 29. Inpatient Rehab For Alcohol And Drug Abuse
- 30. Partial Hospitalization/Substance Abuse Rehab Program (Alternate Benefit)
- 31. Prescription Drugs

ABBREVIATIONS

BC/BS: Blue Cross and Blue Shield COB: Coordination of Benefits

Detox: Detoxification

HMO: Health Maintenance Organization

MAP: Medical Assistance Plan M&N: Mental and Nervous

OB: Obstetrician
OOP: Out-Of-Pocket
PA: Payment Allowance

PPO: Preferred Provider Organization

QCP: Quality Care Program

R&C: Reasonable and Customary

Rehab: Rehabilitation

CHART DEFINITIONS

 Payment Allowance (PA) limits are established for non-PPO charges in each PPO area based upon the negotiated fees charged to BellSouth by PPO providers, such as hospitals, within that area.

Amounts over the PA limits are not covered and will not count toward the deductible or out-of-pocket limit.

- Reasonable and Customary (R&C) limits are established by BC/BS and are based on the amount usually charged most patients for physician fees and certain services and supplies within the same locality.
- 3. Covered Charge: The charge associated with a medically necessary service, supply or procedure incurred by a participant for a non-occupational illness or injury, that is eligible for consideration based on the limits established under the medical plan and that is not excluded by any other provision of the medical plan. In addition, the following rules apply:

In a PPO area, covered charges from a:

- PPO hospital are the charges at the contract rates for covered services negotiated between BellSouth and that hospital.
- Non-PPO hospital are the expenses for covered services which are billed to the non-Medicare-eligible participant <u>up to that PPO area's</u> Payment Allowance (PA).
- PPO or non-PPO hospital are the expenses for covered services which are billed to the Medicare-eligible participant.

In a non-PPO area, covered charges are the expenses for covered services billed from any hospital.

4. In general, **facility fees** refer to semi-private room and board charges and ancillary (other associated) charges.

1 Deductible

Applies to most covered charges. Does not apply toward OOP limit

Family: \$400 (all covered charges applied toward individual deductibles) or 2 individual deductibles, whichever occurs first

2 Out-Of-Pocket Limit

Individual: \$1,000

Family: 2 individual family members completely meeting their OOP limits

The deductible, QCP penalty, covered charges not paid because of COB, Mail Order Prescription Drug Program copayments, expenses not covered at all (such as expenses due to inpatient care for M&N conditions when not certified by QCP or as a result of a lower benefit schedule), expenses above R&C or PA limits (unless Medicare-eligible) and expenses over scheduled amount for outpatient M&N conditions do not count toward the OOP limit

3 Alternate Benefits

QCP certification required; otherwise, no coverage

100% of covered charges for: birthing centers/ nurse midwives; hospice care; extended care/ skilled nursing facilities, home health care; partial hospitalization for a substance abuse rehabilitation program; and expenses due to special arrangements or treatments when medically appropriate

Deductible required

4 QCP Penalty

\$250 for each occurrence for failing to comply with QCP requirements (no calendar year limit)

More than one penalty may be applied for a single hospital confinement

(Facility Fee)

100% of covered charges No deductible

6 In/Outpatient Diagnostic X-Ray And Lab Tests (Facility Fee)

INPATIENT

90% of covered charges Deductible required

If admitted for diagnostic tests only, hospital room and board are not covered

OUTPATIENT

100% of covered charges

90% of covered charges for non-PPO hospital

Deductible required

100% of covered charges 90% of covered charges for non-PPO hospital expenses for non-Medicare-eligible participants who live in a PPO area Deductible required



100% of covered charges 90% of covered charges for non-PPO hospital expenses for non-Medicare-eligible participants who live in a PPO area No deductible

9 Inpatient Surgery (Surgeon Fee)

90% R&C Deductible required

See #21 for benefits effective January 1, 1991

Mandatory Outpatient Surgical Procedures (Surgeon Fee)

100% R&C

See #21 for benefits effective January 1, 1991

All Other Outpatient Surg (Surgeon Fee)

100% P&C Deductible required See #21 for benefits effective January 1, 1991

Mandatory Second Surgical Dpinions (Physician Fee)

100% of covered charges for QCP-listed physi-

100% R&C when physician is QCP-approved but not on QCP list No deductible

No coverage when physician is not QCPapproved or opinion is not authorized by QCP

Requirement may be waived by QCP

13 Anesthesia Administration

90% B&C Deductible required See #21 for benefits effective January 1, 1991



Benefits are payable if covered charges incurred within 72 hours of injury or illness

PRIOR TO 1/1/91

- Ambulatory surgical facility/hospital outpatient department/emergency room fee: 100% of covered charges
- Physician/Surgeon: 90% R&C
- No deductible

EFFECTIVE 1/1/91
SPECIFIED EMERGENCY CONDITIONS such as those resulting in the patient being hospitalized, bone fractures, abrasions, lacerations, poisoning and rape

- · Ambulatory surgical facility/hospital outpatient department/emergency room fee: 100% of covered charges
- Physician/Surgeon: 90% R&C
- No deductible

NON-SPECIFIED EMERGENCY CONDITIONS . PPO facility charges paid in full after \$25 co-

- Non-PPO facility charges paid in full after \$50
- . Copayments do not apply to deductible or OOP
- Physician/Surgeon: 90% R&C
- No deductible

15 Pap Smears (Lab Fee)

100% R&C No deductible

16 Mammogram Screening (Test Fee)

WITH DIAGNOSED CONDITION

90% R&C

Deductible required

ROUTINE (EFFECTIVE 1/1/91)

100% B&C

Limited to one base line for ages 40-49, then annually at age 50 or older

No deductible

In/Outpatient Radiation Therapy And Chemotherapy

100% B&C No deductible

90% R&C (one visit per day) Deductible required

See #21 for benefits effective January 1, 1991

In-Hospital Consultation By Other Than Primary Physician

90% R&C, limited to one consultation per specialty, per admission Deductible required

See #21 for benefits effective January 1, 1991

20 Physician Fee (Office Visit)

Deductible required

See #21 for benefits effective January 1, 1991

21 Physician Fee (Effective 1/1/91)

PPO PHYSICIAN FEE

When implemented, 90% of negotiated fee less participant's \$5 copayment; \$5 copayment does not apply to deductible or OOP limit

NON-PPO PHYSICIAN FEE

90% R&C, after deductible, if participant does not live within PPO area

80% PA, after deductible, if participant lives within PPO area; amount above PA is not covered and will not apply to deductible or OOP limit

22 Maternity Care (OB Fee For Fra And Postnatal Care)

100% R&C No deductible

Effective 1/1/91, 80% R&C, after deductible, if participant lives within PPO area and uses non-PPO physician

23 Well Baby Care

90% R&C for one well baby exam during mother's confinement No deductible

Effective 1/1/91, 80% R&C, after deductible, if participant lives within PPO area and uses non-PPO physician

24 Well Child Care

90% R&C less participant's \$5 copayment for routine exams and immunizations to age 6, annual screening for ages 6-12 (copayment does not apply to deductible or OOP limit)

Prenatal vitamins covered by this provision under MAP's various drug programs

Annual limits: \$250/child (pre and postbirth); \$400/family

No deductible for physician services

25 Chiropractic Charges

90% R&C up to \$100 benefit for first covered visit after January 1, 1990

90% R&C up to \$50 benefit for subsequent visits

Limited to 2 visits per 7 consecutive calendar days and up to 20 visits per year

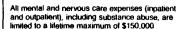
Deductible required

See #21 for benefits effective January 1, 1991; benefit limits and the limit on visits will continue to apply

26 Adoption Coverage

Following adoption, MAP covers up to \$1,000 for eligible medical expenses per child incurred between time of placement in home and court's filing of adoption documents (adopted child must be enrolled)

27 Mental And Nervous Care



INPATIENT CARE
Must be certified by QCP; otherwise, no benefit

Hospital Charges (Other Than Substance Abuse Care)

BENEFITS

Non-PPO

DAYS IN THE HOSPITAL	PPO Hospital Or No PPO Available in Area	Hospital Within Any PPO Area
Less than 30	100% of covered charges	90% PA
30-59	95% of covered charges	85% PA
60-89	90% of covered charges	80% PA
90 or more	85% of covered charges	75% PA

Amount participant pays does <u>not</u> apply to the OOP limit; once OOP limit reached, benefits do <u>not</u> increase to 100%

Participants who live outside the PPO area must use a PPO facility to obtain maximum MAP benefits if receiving treatment within a PPO area

Physician Fees 90% R&C (one visit per day) Deductible required See #21 for benefits effective January 1, 1991

OUTPATIENT CARE Physician Fees

Deductible required

Payment limits:

- \$50 maximum benefit per visit.
- 2 visits per 7 consecutive calendar days
- 52 visits per year

Once OOP limit reached, payment limits still apply

28 Inpatient Detax For Alcohol And

No benefit unless certified by QCP (see #27 for lifetime maximum information)

HOSPITAL CHARGES 100% of covered charges

90% of covered charges for non-PPO hospital expenses for non-Medicare-eligible participants who live in a PPO area

Participants who live outside the PPO area must use a PPO facility to obtain maximum MAP benefits if receiving treatment within a PPO area

Limit: up to 30 days each detox; 2 detox confinements per 5 years

Deductible required

PHYSICIAN FEES 90% R&C

Deductible required See #21 for benefits effective January 1, 1991

29 Inpatient Rehab For Alcohol And June 2018

No benefit unless certified by QCP (see #27 for life-time maximum information)

HOSPITAL CHARGES 100% of covered charges

90% of covered charges for non-PPO hospital expenses for non-Medicare-eligible participants who live in a PPO area

Participants who live outside the PPO area must use a PPO facility to obtain maximum MAP benefits if receiving treatment within a PPO area

Limit: 1 rehab for up to 30 days per lifetime

May substitute partial hospitalization/substance abuse program, but only up to outpatient program cost

Deductible required

PHYSICIAN FEES

Physician's fees must be included in inpatient facility program charge

30 Partial Hospitalization/Substance Abuse Rehab Program (Alternate Benefit)

No benefit unless certified by QCP (see #27 for lifetime maximum information)

100% of covered charges

Participants who live outside the PPO area must use a PPO facility to obtain maximum MAP benefits if receiving treatment within a PPO area

May substitute an inpatient confinement in place of this program, up to partial hospitalization program cost

Limit: 1 program up to 30 days per lifetime

Deductible required

31 Prescription Drugs

Generic drugs covered, namebrands covered if generic not available or generic substitution not allowed by physician; prescribed over-the-counter drugs are not covered.

GENERAL BENEFITS
Generics: 90% R&C, after deductible

Namebrands: 90% R&C, after deductible, if generic not available or generic substitution not allowed by the physician. If generic available and allowed but not chosen, MAP pays 90% R&C of generic cost, after deductible

MAIL ORDER PRESCRIPTION DRUG PROGRAM Up to 90-day supply

Generics: \$4 copayment with \$3 coupon; otherwise, \$7 copayment

Namebrands: \$7 copayment; participant pays cost in excess of generic drug cost when a generic substitution is available and allowed by the physician, but not chosen

PPO PHARMACY NETWORK

When and where PPO network implemented, \$10 copayment per prescription (actual cost if less) for up to a 30-day supply

Participant pays cost in excess of generic drug cost when a generic substitution is available and allowed by the physician, but not chosen

APPENDIX 6

THE PETUSOUTT

Continues and Continues

All claims or questions should be directed to Provident by writing Provident Life and Accident Insurance Company, P.O. Box 12022, Chattanooga, Tennessee 37401 or calling one of the following toll free numbers:

Outside Tennessee 1-800-251-6401 Tennessee 1-800-572-7343 Chattanooga 755-4900

PARTICIPATING COMPANIES

The Dental Assistance Plan is available to the following participating companies (referred to in this booklet as the "Company" or "Companies") who are eligible for coverage under this Plan:

BellSouth Advertising & Publishing Corporation

BellSouth Communications, Inc.

BellSouth Corporation

BellSouth D.C., Inc.

BellSouth Enterprises, Inc.

BellSouth Financial Services Corporation

BellSouth Human Resources Administration, Inc.

BellSouth Information Systems, Inc.

BellSouth International, Inc.

BellSouth Mobility Inc

BellSouth Resources, Inc.

BellSouth Services Incorporated

South Central Bell Telephone Company

Southern Bell Telephone & Telegraph Company

Sunlink Corporation

This list of participating companies may be changed from time to time. You may contact your Benefit Office if you have any question about whether your employer is a Participating Company.



The Company pays the entire cost of the Dental Assistance Plan for all regular full-time employees having six months of net credited service and their eligible dependents. Regular part-time employees having six months of net credited service are eligible to participate, however the amount contributed by the company depends on their date of hire (see page 3).

BellSouth's current intention is to continue the Dental Assistance Plan as described in this booklet, but reserves the right, in its discretion, to amend or terminate the Plan and coverage at any time for active employees, retirees, former employees, and all dependents subject to any applicable collective bargaining agreements.

Eligibility for, or participation in, the Plan does not constitute a guarantee of employment, nor does it interfere with the Company's right to terminate employment.

A "PREDETERMINATION OF BENEFITS" provision lets you and the dentist know in advance how much the Plan will pay.

The Plan pays 100 per cent of the reasonable and customary charges for covered preventive and diagnostic services, called **TYPE A.**

For other covered dental services, called **TYPE B**, the Plan pays according to Schedule. But, before it does, you pay the first \$25 of the scheduled allowances. This \$25 deductible applies separately to each covered person once each calendar year except as shown on pages 4-5.

You have a free choice of dentists.

The Plan covers only certain dental services and procedures. The most common exclusions are listed in this booklet.

Your Dental Assistance Plan coverage will stop at the end of the month you leave the Company (although you may have continuation of coverage rights under COBRA—see page 28 of this booklet). If you retire on a service or disability pension you and your eligible dependents will continue to be eligible for coverage. However, employees retiring on or after January 1, 1988 will have to pay for any dependent (other than a spouse) added to their contract after retiring.

Some major changes have been made to the Dental Assistance Plan since the last Summary Plan Description was issued. The more significant changes include:

- increase in the annual maximum Plan benefit from \$1000 to \$1100 for non-orthodontic expenses effective 7-1-90
- increase of maximum reimbursement for orthondontia expenses (for *only* those under 20 years of age) to \$1320 effective 1-1-90
- effective 7-1-90 the Plan will cover sealants for participants age 13 and under for one treatment per lifetime
- effective 7-1-90 the schedules for Type B services will be expanded.
- effective 1-1-93 the cost of coverage for a retiree, who retires on or after 1-1-92, their spouse and other Class I dependents will be paid by the Company only up to the 1990 actual cost level.

Contents

Page **ipating**

Some Highlights of Your Dental Assistance Plan Part I — Purpose of Dental Assistance Plan Structure of This Booklet Who is Eligible What The Plan Pays. Type A Services—Diagnostic and Preventive Services Type B Services—Other Covered Services Items Not Covered By This Plan How The Plan Works—Examples How The Plan Works—Examples Items Not Covered By This Plan How The Plan Works—Examples Items Not Covered By This Plan How The Plan Works—Examples Items Not Covered By This Plan Items Not Covered By This Plan Items Not Plan Works—Examples Items Not Coverage Stops Items Not File A Claim Questions on Claims Items Not File A Claim Items Not Fil	Companies
Structure of This Booklet Who is Eligible What The Plan Pays Type A Services – Diagnostic and Preventive Services Type B Services – Other Covered Services Items Not Covered By This Plan How The Plan Works – Examples Predetermination of Benefits Alternate Procedures Coordination of Benefits How to File A Claim Questions on Claims When Your Dental Coverage Stops Leave of Absence or Layoff Retirement Other Information About This Plan Introduction Funding Name and Type of Plan Plan Administrator Plan Administrator Plan Administrator Plan Administration Denial of Claim and Appeal Procedures Payment of Benefits Plan Records Plan Records Plan Records Plan Identification Numbers Plan Contributions 24 Plan Contributions	Some Highlights of Your Dental Assistance Diam
Who is Eligible What The Plan Pays. Type A Services – Diagnostic and Preventive Services Type B Services – Other Covered Services Items Not Covered By This Plan How The Plan Works – Examples Predetermination of Benefits. Alternate Procedures Coordination of Benefits How to File A Claim Questions on Claims When Your Dental Coverage Stops Leave of Absence or Layoff. Retirement Other Information About This Plan Introduction Funding Name and Type of Plan Plan Administrator Plan Administrator Plan Administrator Denial of Claim and Appeal Procedures Payment of Benefits Legal Service Plan Records Plan Identification Numbers Plan Continuance Plan Documents Plan Documents Plan Documents Plan Contributions	Part I — Purpose of Dental Assistance Plan
What The Plan Pays Type A Services — Diagnostic and Preventive Services Type B Services — Other Covered Services Items Not Covered By This Plan How The Plan Works — Examples Predetermination of Benefits Alternate Procedures Coordination of Benefits How to File A Claim Questions on Claims When Your Dental Coverage Stops Leave of Absence or Layoff Retirement Other Information About This Plan Introduction Funding Name and Type of Plan Plan Administrator Plan Administrator Plan Administration Denial of Claim and Appeal Procedures Payment of Benefits Legal Service Plan Records Plan Identification Numbers Plan Contributions 24 Plan Documents Plan Contributions	Structure of this Booklet
Type A Services — Diagnostic and Preventive Services. Type B Services — Other Covered Services. Items Not Covered By This Plan How The Plan Works — Examples. Predetermination of Benefits. Alternate Procedures. Coordination of Benefits. How to File A Claim Questions on Claims. When Your Dental Coverage Stops. Leave of Absence or Layoff. Retirement. Other Information About This Plan Introduction. Funding. Name and Type of Plan. Plan Administrator. Plan Administrator. Plan Administration Denial of Claim and Appeal Procedures. Payment of Benefits. Legal Service. Plan Records. Plan Identification Numbers. Plan Contributions. 24 Plan Documents. Plan Contributions.	Who is Eligible
Type A Services — Diagnostic and Preventive Services Type B Services — Other Covered Services Items Not Covered By This Plan How The Plan Works — Examples Predetermination of Benefits Alternate Procedures Coordination of Benefits How to File A Claim Questions on Claims When Your Dental Coverage Stops Leave of Absence or Layoff Retirement Other Information About This Plan Introduction Funding Name and Type of Plan Plan Administrator Plan Administration Denial of Claim and Appeal Procedures Payment of Benefits Legal Service Plan Records Plan Identification Numbers Plan Contributions 24 Plan Contributions	what the Plan Pays
Items Not Covered By This Plan How The Plan Works – Examples Predetermination of Benefits Alternate Procedures Coordination of Benefits How to File A Claim Questions on Claims When Your Dental Coverage Stops Leave of Absence or Layoff Retirement Other Information About This Plan Introduction Funding Name and Type of Plan Plan Administrator Plan Administration Denial of Claim and Appeal Procedures Payment of Benefits Legal Service Plan Records Plan Continuance Plan Contributions 24 Plan Contributions	Type A Services – Diagnostic and Preventive Services
How The Plan Works – Examples	Type B Services – Other Covered Services
Predetermination of Benefits. 12 Alternate Procedures. 13 Coordination of Benefits. 15 How to File A Claim. 15 Questions on Claims. 16 When Your Dental Coverage Stops. 16 Leave of Absence or Layoff. 17 Retirement. 17 Other Information About This Plan. 19 Introduction. 19 Funding. 19 Name and Type of Plan. 19 Plan Administrator. 20 Plan Administration 21 Denial of Claim and Appeal Procedures 22 Payment of Benefits 23 Legal Service 23 Plan Records. 23 Plan Identification Numbers 24 Plan Contributions 25	items Not Covered By This Plan
Predetermination of Benefits. 12 Alternate Procedures. 13 Coordination of Benefits. 15 How to File A Claim. 15 Questions on Claims. 16 When Your Dental Coverage Stops. 16 Leave of Absence or Layoff. 17 Retirement. 17 Other Information About This Plan. 19 Introduction. 19 Funding. 19 Name and Type of Plan. 19 Plan Administrator. 20 Plan Administration 21 Denial of Claim and Appeal Procedures 22 Payment of Benefits 23 Legal Service 23 Plan Records. 23 Plan Identification Numbers 24 Plan Contributions 25	How The Plan Works – Examples1
Alternate Procedures Coordination of Benefits How to File A Claim Questions on Claims When Your Dental Coverage Stops Leave of Absence or Layoff Retirement Other Information About This Plan Introduction Funding Name and Type of Plan Plan Administrator Plan Administration Denial of Claim and Appeal Procedures Payment of Benefits Legal Service Plan Records Plan Contributions 12 Plan Contributions 24 Plan Contributions	Predetermination of Benefits1
Coordination of Benefits	Alternate Procedures
How to File A Claim Questions on Claims When Your Dental Coverage Stops Leave of Absence or Layoff Retirement Other Information About This Plan Introduction Funding Name and Type of Plan Plan Administrator Plan Administration Denial of Claim and Appeal Procedures Payment of Benefits Legal Service Plan Records Plan Records Plan Identification Numbers Plan Continuance 24 Plan Documents 24 Plan Contributions 25	Coordination of Benefits
Questions on Claims16When Your Dental Coverage Stops16Leave of Absence or Layoff17Retirement17Other Information About This Plan19Introduction19Funding19Name and Type of Plan19Plan Administrator20Plan Administration21Denial of Claim and Appeal Procedures22Payment of Benefits23Legal Service23Plan Records23Plan Identification Numbers24Plan Continuance24Plan Documents24Plan Contributions25	How to File A Claim
When Your Dental Coverage Stops 16 Leave of Absence or Layoff. 17 Retirement 17 Other Information About This Plan 19 Introduction 19 Funding 19 Name and Type of Plan 19 Plan Administrator 20 Plan Administration 21 Denial of Claim and Appeal Procedures 22 Payment of Benefits 23 Legal Service 23 Plan Records 23 Plan Identification Numbers 24 Plan Continuance 24 Plan Documents 24 Plan Contributions 25	Questions on Claims
Leave of Absence or Layoff	When Your Dental Coverage Stops
Retirement	Leave of Absence or Lavoff
Other Information About This Plan Introduction Funding Name and Type of Plan Plan Administrator Plan Administration Denial of Claim and Appeal Procedures Payment of Benefits Legal Service Plan Records Plan Identification Numbers Plan Continuance Plan Documents Plan Contributions	Retirement
Funding	Other Information About This Plan
Name and Type of Plan	Introduction
Name and Type of Plan	Funding
Plan Administrator	Name and Type of Plan
Payment of Claim and Appeal Procedures 22 Payment of Benefits 23 Legal Service 23 Plan Records 23 Plan Identification Numbers 24 Plan Continuance 24 Plan Documents 24 Plan Contributions 25	Plan Administrator
Payment of Benefits	Plan Administration2
Plan Records	Payment of Panette
Plan Records	Legal Service
Plan Identification Numbers	Plan Records
Plan Continuance	Plan Identification Numbers
Plan Documents24 Plan Contributions25	Plan Continuance
Plan Contributions25	Plan Documents24
Plan Coverage25	Plan Contributions25
	Plan Coverage25

Your Rights Under ERISA	.25
Your Highls Under Linion	27
Additional InformationCOBRA Continuation of Coverage Requirements	.28
Part II – Location List	.31
Partial Listing of Schedules of Allowance for Type B	
Corvices Most Commonly Performed	.30
Part III - Definition of Common Dental Terms	.42

PART I

PURPOSE OF DENTAL ASSISTANCE PLAN

Your Dental Assistance Plan is designed to:

- Encourage preventive dental care
- Help pay for dental care for you and each of your eligible dependents.

STRUCTURE OF THIS BOOKLET

This explanatory booklet, which is your basic source of information, has three parts:

- A simplified explanation of the Dental Assistance Plan
- Excerpts from the Schedules of Allowances for some of the more common dental services
- Definition of common dental terms to help you understand the Plan.

WHO IS ELIGIBLE

- You, as a regular full-time or regular part-time employee with six months of net credited service
- You, as a retired employee on a service or disability pension
- Your spouse
- Your unmarried children, normally living with you, until the end of the year in which they reach age 19, or until the end of the year in which they reach age 23 if full-time students, or an unmarried child who is physically or mentally handicapped and fully dependent on you for support.

(Children include your natural children and legally adopted children, normally living with you; stepchildren or children for whom you or your spouse are legal guardians, if they live with you. This does not include wards of the state, foster children or custodial appointments.)



PLAN CONTINUANCE

The Company currently intends to continue the Dental Assistance Plan for active employees, former employees and retirees, but reserves the right to amend or terminate the Plan at any time, subject to any applicable collective bargaining agreements. No amendment shall affect payment of benefits already received prior to Plan amendment or termination.

The benefits described in this booklet reflect the provisions of the Dental Assistance Plan as outlined in the current agreements, if any, between the Companies and the various unions representing employees of those Companies in collective bargaining units. Copies of these agreements are distributed or made available to employees covered by them upon request.

EFFECTIVE DATE OF COVERAGE

Your coverage automatically starts on the date on which you obtain six months of net credited service. (Certain Third Country National or Local National employees of BellSouth International, Inc. are excluded from coverage.) Enrollment is required for your eligible dependents. If enrolled, coverage for your dependents will be effective the same day as your coverage, providing the Company pays the full cost of your coverage. If enrolled later, coverage will be effective on the date they meet the eligibility requirements.

If you enroll your dependents after you retire, your dependents' coverage will be effective on the first day of the month after you enroll them.

NOTE: If you retire on or after January 1, 1988, you may provide coverage for any eligible dependent (other than your spouse) added to your contract by paying the full premium rate for each additional dependent.

If you and your spouse both work for the same Company, one of you may waive coverage as an employee and be covered as a dependent under the other's coverage. If you and your spouse are employees of different Companies, each of you is covered only as an employee. Eligible children should be enrolled by the parent whose birthday comes first in a calendar year.

No person can be covered as both an employee and as a dependent under this Plan or as a dependent of more than one employee.

Part-Time Employees

If, on or after January 1, 1990, you are either hired or re-engaged after a service break, you will be required to pay a portion of the cost of your coverage for any periods during which you are classified as regular part-time and during which you work less than 37.5 hours per week. The amount that you will be required to pay will be based upon the ratio of your weekly hours worked to a 37.5-hour workweek.

For example, if you work 7.5 hours each day for three days a week (a total of 22.5 hours each week or 60% of a 37.5-hour workweek), the Company will pay 60% of the cost of your coverage; either individual, two-party or family. You will be required to pay the remaining 40% of the cost.

If you were hired after December 31, 1980, and were on the payroll on December 31, 1989, the amount of the cost of your coverage you will be required to pay—as long as you remain continuously employed thereafter (no service break)—for any periods in which you are classified as a regular part-time employee will be the lesser of the cost in effect on January 1, 1990 described above and the cost for the comparable work time under the rules in effect for the period from December 31, 1980, through December 31, 1989.

As information, scheduled hours determined the percentage paid by the Company for employees hired during the period from 1981 through 1989 based on the following schedule:

Your Weekly Work Schedule	Cost Pald By BellSouth
Less than 16 hours	0%
16 - 24 hours	50%
Greater than 24 hours	100%